

**Massachusetts
Department of
Public Health**

**Bureau of
Infectious
Disease**

**Office of
HIV/AIDS**



Massachusetts State HIV/AIDS Plan

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Executive Summary

A combination of policy and program efforts has contributed to the success of Massachusetts's response to the HIV/AIDS epidemic. Advances in prevention, treatment, and diagnostic technologies coupled with the evolution of the public health and health care delivery system in the context of the federal Patient Protection and Affordable Care Act provide opportunities to further strengthen our response to the epidemic, and thereby build on successes to date.

The Massachusetts State HIV/AIDS Plan (the Plan) articulates key recommendations which, when implemented, will enhance Massachusetts's response to HIV/AIDS and will do so in a way which optimizes resources. The Plan emphasizes policy, structural, and operational adjustments. This reflects an acknowledgement of constrained funding and the evolving policy environment at the local, state, and national levels.

While the Plan is specific to HIV/AIDS, it also articulates recommendations to strengthen Massachusetts's response to hepatitis C virus (HCV) infection, including strategies to enhance programmatic efforts for the prevention, care, and treatment of HCV infection.

The Plan is intended to inform and guide the HIV/AIDS prevention, care, and treatment activities of the Massachusetts Department of Public Health (MDPH). These efforts are led by the Bureau of Infectious Disease (BID) Office of HIV/AIDS (OHA). The success of OHA's efforts depends significantly upon the strength and effectiveness of a broad range of partnerships. Therefore, the Plan should also serve as a guide for and inform the activities of providers, consumers, policy makers, researchers, community leaders, and other stakeholders.

In implementing the Massachusetts State HIV/AIDS Plan, MDPH seeks to achieve three broad goals.

- Goal #1:** Reduce new HIV and HCV infections
- Goal #2:** Improve health outcomes (i.e. reduce disease-related morbidity and mortality)
- Goal #3:** Reduce disparities in HIV and HCV incidence and health outcomes

Four objectives will advance achievement of these goals:

1. Increase knowledge of HIV and HCV status
2. Reduce risk for infection and/or transmission
3. Increase sustained engagement in medical care and treatment
4. Increase HIV viral suppression and sustained HCV virologic response

Promotion and achievement of health equity in the prevention, care, and treatment of HIV/AIDS and HCV is an overarching objective. Efforts and investments must be focused on and tailored to address the needs and priorities of individuals and communities disproportionately impacted by HIV/AIDS and HCV. Most importantly, Massachusetts cannot anticipate ending the HIV epidemic without more effectively addressing prevention and care needs of gay and bisexual men and other men who have sex with men (MSM) of all races/ethnicities, and maintaining focus on the prevention and health protection needs of injection drug users (IDUs).

Implementation of five recommendations will strengthen Massachusetts's response to HIV/AIDS and HCV by enhancing effectiveness, efficiency, and sustainability of programs and services.

Recommendation #1: Strengthen Programmatic Response. Given increasingly constrained resources, coupled with sustained or increasing need, Massachusetts will implement strategies to enhance targeting of services, focus its investments, and provide culturally relevant and responsive services. Massachusetts will also seek to enhance, at the state and local levels, capacity for evaluation and quality improvement essential to strengthening programmatic response.

Recommendation #2: Strengthen the Evidence-Base for Decision Making. To enhance the effectiveness and efficiency of the response to HIV/AIDS and HCV, Massachusetts will expand the use of disease surveillance, service utilization, and other relevant sources of data in planning and evaluation of program and policy. Massachusetts will also seek to address gaps in knowledge about the efficiency, effectiveness, and cost-effectiveness of services by enhancing evaluation of existing services, as well as of promising interventions and service models.

Recommendation #3: Enhance Integration and Continuity of Services. Through refinement of policy and investment in capacity building, Massachusetts will facilitate and promote integration and continuity of communicable disease prevention, care, and treatment services. Through strategic partnerships, Massachusetts will also seek to promote integration and continuity of services in the context of primary care.

Recommendation #4: Leverage Revenue from Third-Party Reimbursements. In order to facilitate a sustainable continuum of services, Massachusetts will implement strategies to increase capacity to, at the state and local levels, participate in third-party billing. Through strategic partnerships, Massachusetts will also seek to promote and facilitate the responsiveness of insurance products to the needs of individuals living with or at risk for HIV/AIDS, HCV, and other communicable diseases.

Recommendation #5: Assure Sustainability of Services. In order to ensure that vital services continue to be available and accessible, Massachusetts will promote and facilitate enhanced collaboration between medical and non-medical providers who provide a range of clinical, social, and supportive services. Through strategic partnerships, Massachusetts will also articulate the public health impact of HIV/AIDS and HCV and the value of sustained investment in public health programming.

The Massachusetts State HIV/AIDS Plan will inform the MDPH's response to HIV/AIDS and HCV. Based on the recommendations and strategies articulated in this Plan, OHA will develop an implementation plan which describes concrete actions that will be taken to achieve the goals and objectives included in the Plan.

OHA's success in achieving the goals and objectives articulated in the Plan is predicated upon robust and successful partnerships with consumers, providers, and other stakeholders. Strategic partnerships are expected to play critical roles in advancing the strategies articulated in the Plan. OHA is committed to transparency with and accountability to stakeholders as it advances the recommendations and strategies contained within the Plan and expects to regularly report on progress and challenges, and seek additional input from partners and advisory bodies in order to refine implementation strategies.

Introduction and Background

The Plan is intended to inform and guide the HIV/AIDS prevention, care, and treatment activities of the MDPH as well as those of providers, consumers, policy makers, researchers, and others.

Massachusetts's response to the HIV/AIDS epidemic has been highly successful. Since 2000 there has been a 44 percent decline in new HIV diagnoses and a corresponding 41 percent decline in deaths among state residents living with HIV/AIDS. This level of effectiveness is attributable to policy and program efforts designed to maximize access to prevention and care services, including Medicaid expansion and state health care reform. However, more remains to be done. Advances in prevention, treatment, and diagnostic technologies along with changes in the policy and funding environment require Massachusetts to reexamine and refine its

approach to the prevention, care, and treatment of HIV/AIDS. Scientific advances coupled with the evolution of the public health and health care delivery system in response to implementation of the Patient Protection and Affordable Care Act (ACA), provide opportunities to strengthen our response to the epidemic, and thereby build on successes to date.

The Massachusetts State HIV/AIDS Plan (the Plan) articulates key recommendations which, when implemented, will enhance Massachusetts's response to HIV/AIDS and will do so in a way which can optimize resources. The Plan emphasizes policy, structural, and operational adjustments. This reflects an acknowledgement of constrained funding and the evolving policy environment at the local, state, and national levels.

The Massachusetts State HIV/AIDS Plan is intended to inform and guide the HIV/AIDS prevention, care, and treatment activities of the Massachusetts Department of Public Health (MDPH). These efforts are led by the Bureau of Infectious Disease (BID) Office of HIV/AIDS (OHA). Because the success of OHA's efforts depends significantly upon the strength and effectiveness of a broad range of partnerships, the Plan should also serve as a guide for and inform the activities of providers, consumers, policy makers, researchers, community leaders, and other stakeholders.

While the Plan is specific to HIV/AIDS, it also articulates recommendations to strengthen the Commonwealth's response to hepatitis C virus (HCV) infection, including strategies to enhance programmatic efforts for the prevention, care, and treatment of HCV infection. The reasons for addressing HCV in this Plan are multiple: both HIV and HCV are chronic infectious diseases of public health significance; the populations impacted by HIV and HCV significantly overlap; the transmission behaviors and contexts of risk overlap; and the care and treatment of HIV/AIDS and HCV are lengthy and often complex owing to co-morbid substance abuse and mental health issues implicated for both. The risks for HIV and HCV infection are grounded in psychosocial vulnerabilities and social determinants of health and require both individual-level and structural responses. Over the more than 30 years of the HIV/AIDS epidemic, a well-developed infrastructure of

HIV and HCV are both chronic diseases of public health significance with similarities in impacted populations, transmission behaviors, broader contexts of risk, and treatment complexities.

services for HIV prevention, care, and treatment has evolved which can and should be adapted to respond to the needs and priorities of individuals and populations affected by HCV. Finally, responsibility for leading and coordinating the Commonwealth's programmatic response to HCV resides with programmatic divisions of the Bureau of Infectious Disease (BID).

Development of the Plan

Success in achieving the goals and objectives articulated in the Plan is predicated upon robust and successful partnerships with consumers, providers, other stakeholders.

The Massachusetts State HIV/AIDS Plan was developed through a highly consultative process, led by OHA, with a broad array of stakeholders. The development process was initiated with a one-day meeting in which nearly 200 individuals participated in facilitated discussion about the Plan, including development of specific recommendations to strengthen the Commonwealth's response to HIV/AIDS. Participants included medical providers, consumers, and representatives of organizations providing HIV/AIDS services (medical and non-medical), public health, behavioral health, and community mental health services.

The discussion and recommendations that emerged from the one-day meeting were synthesized. The synthesis and recommendations were subsequently presented to and discussed with the State's HIV planning group, the Massachusetts Integrated Prevention and Care Committee (MIPCC) and the Massachusetts Statewide Consumer Advisory Board (SWCAB). Both the MIPCC and the SWCAB function as advisory bodies, providing OHA with input and feedback regarding a range of policy and program issues. The MIPCC is comprised of representatives from agencies providing HIV/AIDS and HCV services and individuals representing communities impacted by HIV/AIDS and HCV. The SWCAB is comprised of people living with HIV/AIDS (PLWHA). Recommendations were further refined by OHA senior staff and incorporated into this Plan.

The expertise of OHA and BID staff and leadership contributed to the development of this Plan. State and federal policy, including the White House's National HIV/AIDS Strategy (NHAS), also shaped the development of this Plan.

Status of the Epidemic in Massachusetts

An estimated 26,000 to 28,000 people in Massachusetts are living with HIV, up to 18 percent of whom do not yet know they have HIV. There are currently 18,459 individuals living with HIV/AIDS in the Commonwealth, based upon case reports submitted to MDPH. In 2011, the most recent year for which complete data are available, there were 657 new HIV diagnoses, compared with 1,175 in 2000. This represents a 44 percent decrease in annual diagnoses. The number of deaths among people reported with HIV/AIDS has decreased by 41 percent from 351 in 2000 to 208 in 2011.

Massachusetts has witnessed a 44% decrease in new HIV diagnoses and a 41% decrease in deaths.

In Massachusetts, populations disproportionately impacted by HIV/AIDS include: men who have sex with men, and racial/ethnic minorities, including those born outside of the United States.

Fifty-five percent of newly diagnosed men are members of racial/ethnic minorities, as are eighty percent of newly diagnosed women. To illustrate the health inequities, black (non-Hispanic) individuals make up six percent and Hispanic/Latino individuals make up eight percent of the total Massachusetts population. Forty-one percent of all new diagnoses occur among men who have sex with other men (MSM). Approximately one-third of all new diagnoses occur among individuals born outside of the United States, and 24 percent were reported with an exposure mode of No Identified Risk (NIR), the second largest exposure mode group among newly diagnosed individuals.

Since 2002, 7,000 to 10,000 newly diagnosed cases of HCV infection have been reported annually to MDPH and it is estimated that there are 100,000 individuals in the Commonwealth that have been exposed to HCV. Among those who died with a known HCV infection through 2009, the median interval between diagnosis with HCV infection and death was three years, and the median age of death attributable to HCV infection was 53 years.

While HIV infection among injection drug users (IDUs) in Massachusetts has declined significantly—92 percent in the past decade—there has not been a similar decrease in HCV infection in this population. In 2012, 70 percent of reported confirmed HCV infections that had risk factor information reported, had a history of injecting drugs. In the U.S., studies suggest that the prevalence of HCV among injecting drug users ranges from 40 to 90 percent.^{1,2}

There has been a significant increase in HCV infection among young IDUs in Massachusetts that may signal the future direction of the HIV epidemic; annual reports of new HCV diagnosis in individuals between the ages of 15 and 24 years increased by 74 percent between 2001 and 2009. Most of these individuals were likely exposed to HCV recently. Transmission in this age group is attributable primarily to injecting heroin and prescription opiates.

Nearly one-third of people living with HIV/AIDS are co-infected with HCV. Overall, HCV co-infected persons make up 15 percent of new HIV/AIDS diagnoses in Massachusetts. Among injecting drug users living with HIV, up to 59 percent are co-infected with HCV. While antiretroviral therapy has extended the life expectancy of people living with HIV, liver disease primarily related to HCV infection is a leading cause of non-AIDS related deaths among PLWHA.

Approximately 100,000 Massachusetts residents have been exposed to HCV and there are up to 10,000 new infections per year. A significant portion of these new infections are among 15-24 year olds.

¹ Hagan, Pouget, Williams, et al. J Infect Dis. 2010; 201:378-385.

² Page, Hahn, Evans, et. Al. J Infect Dis. 2009; 200:1216-1226.

In summary:

- Mortality from HIV has decreased, and prevalence has increased.
- The number of new HIV diagnoses has decreased, but nearly one in five individuals living with HIV may not be aware of their infection.
- A significant proportion of individuals have concurrent HIV and AIDS diagnoses.
- HIV/AIDS disproportionately impacts vulnerable populations, particularly:
 - Gay and bisexual men and other men who have sex with men (MSM)
 - Racial/ethnic minorities, notably non-Hispanic black and Hispanic/Latino individuals
 - Non-U.S. born state residents
- HCV contributes significantly to morbidity and mortality among PLWHA.
- HCV infection is increasing dramatically, related to injecting drug use particularly among adolescents and young adults, which has implications for the future direction of the HIV epidemic.

A more detailed discussion of the impact of HIV/AIDS in Massachusetts is available on the OHA website at www.mass.gov/dph/aids in the [Massachusetts Epidemiologic Profiles](#) section.

Goals and Objectives

In implementing the Massachusetts State HIV/AIDS Plan, MDPH seeks to achieve three broad goals.

Goal #1: Reduce new HIV and HCV infections

Goal #2: Improve health outcomes (i.e. reduce disease-related morbidity and mortality)

Goal #3: Reduce disparities in HIV and HCV incidence and health outcomes

Health equity for MSM, IDU, and racial/ethnic minority populations related to the prevention, care, and treatment of HIV/AIDS is an overarching objective.

Four objectives will advance achievement of these goals:

1. Increase knowledge of HIV and HCV status
2. Reduce risk for infection and/or transmission
3. Increase sustained engagement in medical care and treatment
4. Increase HIV viral suppression and sustained HCV virologic response

Promotion and achievement of health equity in the prevention, care, and treatment of HIV/AIDS and HCV infection is an overarching objective. Efforts and investments must be focused on and tailored to address the needs and priorities of individuals and communities disproportionately impacted by HIV/AIDS and HCV. Most importantly, Massachusetts cannot anticipate ending the HIV epidemic without more effectively addressing prevention and care needs of gay and bisexual men, and other men who have sex

with men (MSM) of all races/ethnicities, and maintaining focus on the prevention and health protection needs of injection drug users (IDUs).

Expected Impact

Massachusetts expects reductions in the number of new HIV infections, in health disparities related to HIV diagnosis, in HIV mortality, and in the number of opportunistic infections.

Progress toward achievement of the goals articulated in this Plan will be assessed through monitoring of selected impact measures, presented below. By 2016 the Commonwealth will:

1. Reduce newly diagnosed HIV infections by 5%, from 660 to 627.
 - a. Reduce new HIV infections among MSM by 2%, from 271 to 266.
 - b. Reduce new HIV infections among black residents by 5%, from 208 to 198.
 - c. Reduce new HIV infections among Hispanic/Latino residents by 3%, from 188 to 182.
2. Reduce the disparity in relative rates of new infections between:
 - a. Black and white residents by 20%, from 10 to 8 times.
 - b. Hispanic/Latino and white residents by 25%, from 8 to 5.25 times.
3. Reduce mortality in PLWHA by 12%, from 257 to 226.
 - a. Reduce mortality among IDU with HIV infection by 25%, from 89 to 69.
4. Decrease incidence of opportunistic infections among PLWHA by 25%, from 104 to 78.
5. Increase by 10% the proportion of HCV antibody positive cases that receive a nucleic acid amplification test (NAAT) or other test to confirm active infection, from 55 % to 65%.
6. Increase by one year the median survival time from diagnosis of individuals with HCV infection from 53 to 54 years.

Impact measures are based on currently available data and reflect cases reported through June 1, 2013. As data systems mature and data sets become more robust, these measures will be refined and/or replaced. Baseline and targets will be updated as necessary.

Massachusetts also expects an increase in the number of people who receive follow-up HCV testing and an increase of survival for people living with HCV.

Recommendations and Strategies

The recommendations and strategies presented below are intended to strengthen Massachusetts's response to HIV/AIDS and HCV by enhancing effectiveness, efficiency, and sustainability of programs and services.

Massachusetts will enhance targeting of services, focus investments, and provide culturally relevant and responsive services.

Recommendation #1: Strengthen Programmatic Response.

Given increasingly constrained resources, coupled with sustained or increasing need, it is critical to direct efforts in a way which will optimize resources and have the greatest impact.

Strategies to achieve a strengthened response include:

- *Refine and strengthen targeting of services.* Decisions regarding targeting should be data-driven and services should be targeted according to:
 - Population: Priority should be placed on serving populations disproportionately or increasingly impacted by HIV/AIDS and/or HCV.
 - Geography: Proportionally prioritize geographic areas of the Commonwealth which have the greatest disease burden or increasing incidence.
 - Venue: Prioritize venues which serve and/or can provide access to populations at highest risk and/or hard-to-reach (e.g. correctional facilities or public sex environments).
 - Acuity: Implement strategies (e.g. risk screening or acuity assessments) to identify individuals at highest risk, in greatest need, and/or who could most benefit from services.
- *Focus program efforts and investments.* Interventions and services should be evidence-based and aligned with achievement of the overarching goals articulated in this Plan. Priority should be placed on strengthening interventions and services that align with achieving programmatic objectives.
- *Construct a service portfolio responsive to community needs and provider capacities.* In constructing a service portfolio:
 - Employ a mixture of strategies, technologies, and models. Implementation of a range of interventions and services facilitates responsiveness to the unique needs of clients and communities, and enables delivery of interventions and services within the resources and capacities of a range of service providers. A particular emphasis should be placed on reducing service gaps and increasing alignment and collaboration within regional networks of providers with complementary capacities, notably medical and non-medical providers.

- Adopt new and emerging tools and technologies to facilitate responsiveness to the evolving needs of clients, populations, and communities, as well as capacities and resources of service providers.
- Collaborate with health economists to identify the mix of strategies that will result in the greatest impact with regard to reducing incidence and promoting positive health outcomes.
- Pilot promising interventions and service models (e.g. brief strengths-based case management, novel testing technologies). Pilots should be accompanied by robust evaluation to identify what works and where in order to inform replication.
- Implement health communications/social marketing campaigns designed to increase awareness of disease impact, drive service access and utilization. Address stigma and norms implicated in risk, and that create barriers to prevention, care, and treatment.
- *Strengthen capacity for programmatic monitoring, evaluation, and quality improvement.* It is critical to ensure that program efforts are targeted, tailored, effective, and efficient, and accomplish the intended health outcomes. Monitoring and evaluation (M&E) and quality improvement (QI) facilitate identification and leverage of programmatic strengths and/or focus in on areas where opportunities for improvement exist. They also enhance accountability. Strategies for strengthening M&E and QI include:
 - Address M&E and QI in program standards for HIV and HCV prevention, care, and treatment services.
 - Strengthen contract management protocols and procedures with regard to assessing the implementation of M&E and QI activities by providers of HIV and HCV prevention, care, and treatment services.
 - In collaboration with academia or other sources of relevant expertise, enhance the capacity of service providers to perform M&E and QI of HIV and HCV prevention, care, and treatment services. Capacity building strategies may include development and dissemination of guidelines and sample tools and protocols, education and training, and individualized technical assistance.
- *Strengthen capacity to provide culturally relevant and appropriate services with regard to race/ethnicity, sexual orientation, gender identity, country of origin, age, HIV and HCV infection status.* HIV and HCV prevention, care, and treatment services must be culturally relevant and appropriate in order to be effective. Providers of such services must have the knowledge, skills, and competencies to provide such services. Strategies to strengthen capacity to provide culturally competent services may include:
 - Address cultural competence in program standards for HIV and HCV prevention, care, and treatment services.
 - Strengthen contract management protocols and procedures with regard to assessing the cultural competence of HIV and HCV prevention, care, and treatment services.
 - Enhance the capacity of service providers to provide culturally, linguistically, and developmentally competent services. Capacity building strategies may include

Massachusetts seeks to enhance capacity for evaluation and quality improvement at state and local levels.

- development and dissemination of guidelines, education, training, and individualized technical assistance. Collaborate with state, regional, and national partners in provision of capacity building assistance (e.g. National LGBT Health Education Center).
- Partner with other MDPH programs (e.g. Bureau of Substance Abuse Services) to strengthen the cultural competence of substance abuse, mental health, and correctional health providers with regard to sexual minorities and drug users.

Massachusetts will use disease surveillance and service utilization data for planning and evaluation.

Recommendation #2: Strengthen the Evidence-Base for Decision Making.

The effectiveness and efficiency of Massachusetts's response to HIV/AIDS and HCV is predicated upon well-informed decision-making.

Strategies to strengthen the evidence-base for decision making include:

- *Expand and enhance use of disease surveillance data including electronic laboratory reporting (ELR) and provide timely and relevant analysis to providers and other stakeholders.* These data can inform program planning, evaluation, and quality management as well as stimulate practice improvement at state, regional, and provider levels. Novel uses could include:
 - Generate state, regional, and facility-specific care cascades. Provision of support to providers will be needed to assure timely application of these data to program planning, evaluation, and practice improvement efforts.
 - Use surveillance data to identify out-of-care clients or clients who may be receiving sub-optimal care. Strengthening the relationship between providers and disease surveillance and disease intervention programs will be essential to support this novel use of data.
 - Calculate HIV community viral load estimates and assess their usefulness to focusing program response and investments.
 - Perform combined analysis of disease surveillance data from related health areas (e.g. HIV, sexually transmitted infections, HCV, tuberculosis) to gain a better understanding of co-occurring morbidity and to identify emerging trends. Provision of support to providers will be needed to assure timely application of these data to program planning, evaluation, and practice improvement efforts.
- *Strengthen and expand application of service utilization data to program planning, evaluation, and quality improvement efforts.* Service utilization data are essential to describe program investments, monitor progress toward achieving goals and objectives, evaluate the effectiveness and efficiency of services, and inform quality management. Data systems, including analytic and dissemination strategies, must enable and optimally facilitate these functions across a continuum of prevention and care services. Actions needed to strengthen and expand application of service utilization data include:
 - Develop a comprehensive monitoring and evaluation (M&E) plan to articulate goals, objectives and expected outcomes, and to inform data collection, management and application plans and priorities. The M&E plan should be responsive to national

performance standards and articulate benchmarks against which progress can be monitored.

- Refine and streamline existing data collection requirements and data management strategies to ensure essential data elements are collected, while simultaneously reducing reporting burden.
- Develop data management systems and processes which assure integration of service utilization data across the continuum of prevention and care services, which reflects communicable disease service integration; which enables use of service utilization data in conjunction with disease surveillance, and other sources of client-level data; and which assures providers real-time access to service data needed for program monitoring and quality management.
- Implement mechanisms to assure that service utilization data for related programs supported by MDPH (such as refugee and immigrant health programs, substance abuse services, tuberculosis, and correctional health) are routinely analyzed to monitor responsiveness to standards of care, health outcomes, and fidelity to intervention and service guidelines; and to identify gaps in services and opportunities for enhanced collaboration and service integration.
- *Address critical gaps in knowledge about the efficiency, effectiveness, and cost of services through evaluation of existing services, as well as of promising interventions and service models.* This knowledge is essential to ensure resources are invested in services and activities that will result in improved outcomes and which optimize resources and achieve cost-efficiencies. Strategies to address knowledge gaps include:
 - Implement outcome-based monitoring of prevention and care services and assure that outcome standards are clearly articulated and are consistent across related programs supported by MDPH (e.g. refugee and immigrant health programs, substance abuse services, correctional health).
 - In collaboration with academic, community, and other partners implement, via pilot or demonstration projects, evaluation of essential prevention and care services (e.g. population-based screening, patient navigation, HIV/HCV prevention strategies for young IDUs, and medical case management) to provide evidence of the effectiveness of achieving health outcomes, as well as cost-effectiveness of these services.
 - In collaboration with academic, community and other partners implement, via pilot or demonstration projects, evaluation of new and promising interventions and service models (e.g. case management for high-risk negatives or HCV mono-infected individuals, pre-exposure prophylaxis for HIV). Evaluation activities should support and guide replication of demonstrably effective interventions and service models.
- *Explore novel uses for existing data sets to focus and evaluate program efforts and the impact of policy decisions.* Data gathered by other programs and for other purposes can be useful for program planning and evaluation and should be used to ensure a more robust base of knowledge from which to make decisions. For example, research demonstrates an

Massachusetts will work to increase knowledge about the efficiency, efficacy, and cost-effectiveness of various HIV-related services.

association between HIV seroprevalence and low socioeconomic status. Use of census tract data may be useful in focusing prevention efforts.

Strategic partnerships will promote integration and continuity of services for the prevention, care, and treatment of HIV, HCV, and STIs.

Recommendation #3: Enhance Integration and Continuity of Services.

Integrating prevention, care, and treatment services for HIV, HCV, STIs, and other communicable diseases can improve the quality and continuity of client care as well as the efficiency of service provision.

Strategies to enhance integration and continuity of services include:

- *Promote and facilitate integration and continuity of communicable disease prevention, care, and treatment services supported by MDPH through implementation of enabling policy.* Policy adjustments that can promote and facilitate integration and continuity include:
 - Promote and facilitate across MDPH program areas (e.g. infectious disease, substance abuse services, and family planning), unified program standards for HIV, STI, HCV, and other communicable disease prevention, care, and treatment services.
 - Promote and facilitate across MDPH program areas (e.g. infectious disease, substance abuse services, and family planning), health outcome indicators that reflect accountability for achieving continuity in HIV and HCV prevention and care services.
 - Integrate procurements, if feasible, for HIV and HCV prevention, care, and treatment services and/or adopt consistent contractual requirements, program standards, and accountability measures across procurements supporting such services.
 - Leverage state, federal, and other resources (e.g. private or foundation resources) to afford maximum flexibility to local providers in offering a full range of HIV and HCV prevention, care, and treatment services, to eligible clients regardless of HIV status.
 - Expand advisory body membership to ensure representation of consumer perspectives and provider expertise across HIV, HCV, STIs, and other communicable diseases.
 - Promote a coordinated state response to HIV and HCV prevention and care across state agencies (e.g. Department of Elementary and Secondary Education, Department of Corrections) and with local boards of health. Achievement of the goals and objectives articulated in this Plan are predicated upon coordination of activities and resources among agencies and across levels of government.
- *Strengthen the capacity of local service providers to integrate and provide continuity in communicable disease prevention, care, and treatment services.* A variety of capacity building strategies, modalities, and partners can be considered including:
 - Facilitate and support cross-training of prevention, care, and treatment providers, in a range of settings and venues (e.g. community health centers, substance abuse treatment, corrections, community-based organizations), regarding the importance of and strategies to integrate HIV, HCV, and STI prevention, care and treatment services.

- In collaboration with the Ratelle HIV/STD Prevention Training Center (PTC), the New England AIDS Education and Training Center (NEAETC), and others (e.g. medical, dental, and nursing associations) advance integration of public health and prevention strategies including pre-exposure prophylaxis for HIV (PrEP), partner services, and prevention counseling into medical care, including medical care for HIV and HCV infection.
- *Promote and facilitate integration of HIV and HCV prevention, care, and treatment services into primary care.* Strategies may include:
 - Collaborate with the Massachusetts League of Community Health Centers to implement a campaign and associated capacity building activities designed to advance implementation of routine screening for HIV and HCV, pursuant to state and federal recommendations, as a component of primary care.
 - Partner with the New England AIDS Education and Training Center (NEAETC) and others (e.g. medical, dental, and nursing associations) to promote and build capacity for the medical management of HIV and HCV (including HIV/HCV co-infection) in the context of primary care, including support for adoption of strategies such as expert clinical consultation and telemedicine.

Leveraging third-party reimbursement enables redirection of grant and categorical funds to other priority services.

Recommendation #4: Leverage Revenue from Third-Party Reimbursements.

With increasingly constrained resources, revenue generated by participation in third-party billing will allow other funds, including those made available through federal grant opportunities, to be directed to other critical program areas and activities.

Recommendations to leverage revenue generated from third-party reimbursement include:

- *Address gaps in knowledge with regard to billing opportunities for prevention and care services, and the resulting impact on access to and utilization of these services.* In collaboration with providers, consumers, and other stakeholders, conduct formative research to describe and quantify the potential impacts that mandated billing of third-party payers has for access to and utilization of a range of HIV/AIDS, HCV, and other communicable disease services. Findings from research should inform MDPH policy changes regarding third-party billing for such services.
- *Increase revenue for prevention and care services through reimbursement from third-party payers.* Leveraging resources available through third-party reimbursement enables redirection of grant and categorical funds to other priority services and activities which are not reimbursable. Actions to support building capacity for and implementation of third-party billing and reimbursement include:
 - Identify and describe essential prevention and care services and assess which are and are not reimbursable by third-party payers. Assess which services are reimbursable and in which contexts (e.g. by venue or credentialing of service provider), as well as the amount of reimbursement provided.

- Assess MDPH and local provider capacity for and current practices with regard to participation in third-party billing and reimbursement. Use findings from assessment activities to inform capacity building activities.
 - Assess billing requirements across provider and venue types, including medical and non-medical agencies, and identify requirements to function as an authorized biller by provider license or certification; and/or strategies to enable reimbursement of services delivered by agencies that may lack the capacity to directly participate in third-party billing and reimbursement.
 - In partnership with related programs (e.g. refugee and immigrant health, substance abuse services), identify and adopt strategies (e.g. certification programs) that, where feasible, facilitate third-party reimbursement of services provided by peers, community health workers, and others.
 - Assess the extent to which prevention and care (e.g. HIV, HCV, and STI screening, prevention services, patient navigation, and medical case management) services are successfully reimbursed by MassHealth.
 - In partnership with the state Office of Medicaid explore opportunities to establish HIV Health Homes, established by section 2703 of the Affordable Care Act, entitled “State Option to Provide Health Homes for Enrollees with Chronic Conditions” as a mechanism to enhance care coordination and health outcomes for PLWHA who are Medicaid beneficiaries.
 - Ascertain costs associated with provision of essential prevention and care services. Understanding the cost of specific services can inform setting payment rates to adequately reimburse for services provided. Cost calculations should reflect complexity of needs and services.
 - In collaboration with the Center for Health Information and Analysis (CHIA) investigate potential rate structures for HIV and HCV prevention and care services that would be in compliance with chapter 257 of the Acts of 2008. Providers will require technical assistance to implement billing in compliance with c. 257.
 - Facilitate provision of capacity development and technical assistance to support and enhance the successful participation of providers in third-party billing and reimbursement.
 - Expand provider participation in third-party billing and reimbursement through policy interventions such as mandating that MDPH-funded providers obtain insurance information at intake and that those providers with the capacity to do so, seek reimbursement for billable services (e.g. HIV screening).
- Capacity building, technical assistance, and policy development activities will support providers as they explore and take advantage of third-party billing opportunities.***
- *Facilitate responsiveness of insurance products to the needs of individuals living with or at risk for HIV/AIDS, HCV, and other communicable diseases.* In order to obtain maximum benefit of health care reform, the needs of individuals living with and at risk for HIV/AIDS, HCV and other communicable diseases must be adequately addressed by insurance

products such as essential health benefits, drug formularies, and prescription coverage. Actions to facilitate responsiveness may include:

- Advocate with the state Office of Medicaid and other third-party payers as well as the Commonwealth Connector Board to ensure that insurance products are responsive to the needs of individuals living with and at risk for HIV/AIDS, HCV, and other communicable diseases and are adequately addressed in formularies, essential health benefits, and prescription coverage.
- In collaboration with academic, community, and other partners, implement a demonstration project that makes a business case for the cost-effectiveness of prevention and care services including population-based screening for HIV and HCV; medical case management services (for individuals living with HIV/AIDS, mono-infected with HCV, and co-infected with HIV and HCV); peer support, and patient navigation services.

Massachusetts will promote and facilitate enhanced collaboration between medical and non-medical providers to support provision of a continuum of prevention and care services.

Recommendation #5: Assure Sustainability of Services.

Changes to the health care system stimulated by implementation of ACA, combined with uncertain funding for HIV/AIDS and HCV services, and other factors (e.g. advances in treatment) require adjustments in the service delivery system and approach in order to ensure that vital services are available and accessible to the individuals and communities which need them.

Strategies to ensure sustainability of services include:

- *In collaboration with community leaders, consumers, and other stakeholders articulate the public health impact of HIV/AIDS and HCV and the importance of making a sustained investment in prevention, care, and treatment services. Highlight the continued need for and role of public health and community partners in a post-health care reform environment.*
- *Promote and facilitate enhanced coordination and collaboration between medical and non-medical providers to assure access to a range of services responsive to client needs and priorities. Strategies may include:*
 - Implementing various models of inter-agency collaboration including staff “out-posting,” co-location of services, and regional service networks. Operational models should be evaluated to assess effectiveness in facilitating access to and continuity of services.
 - Promote and facilitate collaborations between community health centers and non-medical community-based service providers to implement health home models for the care and treatment of HIV and HCV, including HIV/HCV co-infection.
 - Translate lessons learned from the Massachusetts demonstration project of dually-eligible Medicaid/Medicare beneficiaries to transforming the HIV/AIDS services system into an Integrated Care Organization (ICO) model.

- *Identify and implement strategies to consolidate prevention, care, and treatment services.* Consolidation of services through organizational merger, joint operating agreements, sub-contracts, and/or memoranda of agreement can help to achieve efficiencies (e.g. reducing administrative costs), ensure continued access to services, and enhance integration and continuity of services.

Discussion and Next Steps

The Massachusetts State HIV/AIDS Plan will inform the MDPH's response to HIV/AIDS and HCV. Based on the recommendations and strategies articulated in this Plan the OHA will develop an implementation plan to describe concrete actions that will be taken by OHA, and associated timelines to achieve the goals and objectives presented in the Plan.

The extent to which OHA can be successful in achieving the goals and objectives articulated in the Plan will be predicated upon robust and successful partnerships with consumers, providers other stakeholders. Partners play critical roles in enacting the recommendations and strategies articulated in the plan. For this reason, OHA will disseminate the Massachusetts State HIV/AIDS Plan widely and will encourage stakeholders to align activities with the Plan. OHA will also use dissemination of the Plan as an opportunity to promote collaboration and partnership.

The Office of HIV/AIDS is committed to transparency with, and accountability to, stakeholders as it advances the recommendations and strategies contained within the Plan and expects to regularly report on progress and challenges, and seek additional input from partners and advisory bodies in order to refine its approach and strategies. Mechanisms through which OHA will demonstrate accountability to stakeholders will be addressed in a forthcoming Implementation Plan.

Massachusetts will be transparent with, and accountable to, all stakeholders as the Plan is implemented.